

Rate Review White Paper

As Approved by the Rate Review Plan Management Team on June 11, 2012

The purpose of this white paper is to assist state policymakers with the implementation of the Affordable Care Act (ACA) provisions related to health insurance rating, rate filing, and rate review. The focus of the paper is the rate review requirements related to the certification of Qualified Health Plans (QHPs) in the Exchanges, but many of the ACA provisions impacting rate review apply to all plans in the individual and small group.

I. Introduction

The Affordable Care Act (ACA) includes several provisions that will affect health insurance rating and rate review. These provisions include requirements for the review and disclosure of rate increases above certain defined thresholds, rating and underwriting requirements and limitations, programs to mitigate adverse selection and pricing risk, and additional requirements placed on plans offered through Exchanges. Though some of these provisions have already been implemented, those with a significant impact on rating will be effective for plan years beginning on or after January 1, 2014. Rates reflecting these changes will need to be developed and filed by issuers and reviewed by regulators, as applicable, in advance of January 1, 2014, and in the case of Qualified Health Plans (QHPs) offered through the Exchange, rates will need to be approved, if applicable, prior to open enrollment expected to begin October 1, 2013.

Issuers and regulators will need to create a process for developing, submitting and reviewing rates that allow for potential differences between grandfathered and non-grandfathered plans, plans inside and outside the Exchange, plans by market if states have varying levels of review authority and effective rate review designations, and rate increases, where applicable, at or above defined thresholds (currently 10%) versus those under the defined thresholds. Additionally, rate review processes and requirements should be consistently applied for multi-state plans and Co-op plans to maintain a level playing field. Rating and plan accounting will also need to take into consideration new payments and charges to plans, including those for risk adjustment, reinsurance, risk corridors, rebates associated with medical loss ratio requirements, and any new federal or state taxes and assessments. The rating process will also need to account for several potentially significant changes in the market, including covering new populations and benefits, adhering to new adjusted community rating requirements and underwriting limitations, pooling risks across products within a market (or in some cases across markets), and changes in the small group market.

The ACA also creates roles related to rate review for both the federal government and new Exchange entities. Exchange governance and functional responsibilities will vary across states and may include various combinations of state regulators, Exchange entities and the federal government. The federal government will specifically play a role in rate review in cases where states either do not have an “effective rate review program” or do not establish certified state based or plan management partnership Exchanges. States might consider how to effectively and efficiently work with these various entities to ensure non-duplication, maintain consistency within the market, and mitigate issuer burden and consumer confusion.

II. Individual and Small Group Rate Review in the States before the ACA

State oversight of health insurance rates has, historically, varied substantially. While many states review proposed increases to determine if they are reasonable before they are used in the marketplace, other states lack the legal

authority or resources to review rates prior to their implementation. Some States had no authority whatsoever to deny or reduce proposed rate increases.

A. Types of Rate Regulation

There are four main types of rate regulation in place in the individual and small group markets today:

1. **Actuarial Justification:** In markets with actuarially justified rating requirements, issuers must demonstrate a correlation between case characteristics and increased medical claims costs. The NAIC has adopted safe harbors for case characteristics commonly used for setting premiums within which plans may generally vary rates without providing justification. These are used by most states. Plans that vary rates in excess of these safe harbors may be required to submit data justifying their use of the characteristics in question.
2. **Rating Bands:** Particularly in the small group market, many states have implemented rating bands that limit the variation in premiums attributable to health status and other characteristics. Rating bands are either expressed as a ratio of the highest rating factor to the lowest (e.g. 1.5:1) or as the allowable variation above and below an index rate (e.g. +/- 25%). Rating bands may also take the form of composite rating bands that place limits on the combined effects of multiple case characteristics (e.g., a composite rating band that allows 4:1 variation based upon health status, age, gender, industry, and group size combined).
3. **Adjusted Community Rating:** Adjusted (or modified) community rating laws prohibit the use of health status or claims experience in setting premiums. Other case characteristics, such as age and geography, may be used to vary premiums, though limits may be placed upon these factors as well.
4. **Community Rating:** "Pure" community rating laws prohibit the use of any case characteristics besides geography to vary premiums.

B. Commonly Used Risk Classifications

Following is a list of some of the more commonly allowed risk classifications. Use of these classifications varies greatly from state to state.

1. **Health status and claims experience:** The most direct way for issuers to base premiums on expected costs for an individual or group is to use health status information collected during the underwriting process or claims experience for policies being renewed. Most states that allow health status to be used for rating purposes in the small group market limit it using rating bands that vary from +/-10% to +/-60%. Premium increases due to changes in a business' health status may also be limited to 15% per year in many states.
2. **Age:** Because an individual's health status deteriorates as he or she grows older, leading to increased claims, age has become one of the most commonly employed case characteristics. Under the NAIC safe harbor guidelines, overall variation of 5:1 or less is reasonable in the small group market based upon the expected claims costs of 22-year-olds and 62-year-olds.
3. **Gender:** During childbearing years, women can be expected to incur medical costs that are more than 45 percent higher than men, excluding the costs of normal maternity coverage. The difference in expected claims narrows with increasing age and by their mid-50s men surpass women. At age 62, men can be expected to have costs that are at least 17 percent higher than women.

4. **Group size:** Issuers often charge higher rates to smaller companies for a two main reasons: 1) it is more expensive to issue and service a policy for a very small business than for a larger one; and, 2) small employers purchasing coverage are more likely to have greater knowledge of their employees' potential future needs for health care services, creating a greater risk of adverse selection for the issuer. This risk is higher in a guaranteed issue environment where denial of coverage based upon underwriting criteria is prohibited, and businesses with 1-4 employees may be charged as much as 20% than those with 10-24 employees.
5. **Industry and occupation:** Working conditions and the type and lifestyles of workers may lead to higher claim costs in some industries than in others. The NAIC has adopted a safe harbor of 15 percent for premium variation due to industry in the small group market. Occupation is also often used as a factor in the non-group market.
6. **Geographic location:** The cost of delivering care varies dramatically from one area to another, and issuers often vary their rates by county or by ZIP-code using the employer's business address in the small group market, or the applicant's home address in the individual market. Safe harbors for geography have been set for each state, depending on the variation in medical costs within the state, and range from no variation in the District of Columbia to 1.9:1 in Florida. Not all states allow use of the safe harbor.
7. **Duration of coverage:** In medically underwritten, guaranteed-renewable markets, an issuer has the best picture of the health of enrollees on the date that they submit their application. Over time, enrollees' health may deteriorate from what it was at the time of application, leading to higher claims costs. To offset this, issuers in the individual market will often charge higher premiums to individuals who have been enrolled in the same plan for several years. This practice can encourage healthy enrollees who can pass medical underwriting to reapply in order to get the lower, new enrollee rate, exacerbating the very phenomenon it is attempting to fix.
8. **Wellness:** In recent years, several states have allowed carriers in the individual market to provide premium discounts or other incentives to individuals participating in wellness programs in order to encourage them to adopt healthier lifestyles. In practice, this has been a difficult policy to implement without allowing carriers a back-door way to use health status in setting premiums, and in at least one state where it is allowed no carriers are using it. State flexibility and further study of the best way to use wellness in setting premiums may be warranted.

C. Pooling of Risk

In applying rating factors, carriers will group policyholders into classes and blocks of business.

1. **Class of Business:** Issuers will maintain different "classes of business" that reflect administrative differences in how policies within them were sold or acquired by the company. For instance, a company may maintain one class of business composed of policies sold by its agents in the regular market, a second class of business may contain policies sold through a purchasing pool, while a third may be made up of policies that were acquired from another issuer. Most states limit both the number of classes that an issuer may maintain and the variation of premiums between classes. Most states with community rating or adjusted community rating disallow the maintenance of separate classes of business. The 1993 NAIC Small Employer Health Insurance Availability Model Act, which is the basis of most states' small group rate regulation, limits carriers to nine classes of business and limits the index rate for the highest priced class of business to 120% of the index rate for the lowest priced class of business.

2. **Block of Business:** Issuers will also group business by the form of the policy, creating a block of business. In the individual market, carriers will also create “rating blocks” based upon initial health status classification. For instance, a carrier may group all new business that is charged a 25 percent health adjustment into a single block and then apply experience adjustments to the entire block, rather than reunderwriting each renewed policy every year. When carriers stop actively selling a block of business, the result is a closed block, which can experience rate spirals as those who can pass medical underwriting purchase other coverage, leaving a pool of risk that becomes progressively sicker. In the small group market, limitations on the use of rating factors apply across all blocks of business.

D. Rate Review Processes

Many states use “prospective” regulation of rates, while others use “retrospective” regulation. Prospective regulation includes prior review and/or approval of rates, while retrospective regulation includes “file and use” where the rates go into effect, but the regulator can take action if the rates are later determined to be unreasonable under a standard such as one of the above. Retrospective regulation often relies on consumer complaints to indicate a problem with a company’s rates.

The NAIC has several documents to provide guidance to the states in rate review, including the Health Policy Rate and Form Filing Model (#165), the Guidelines for Filing of Rates for Individual Health Insurance Forms (#134), and the Small Group Rating Compliance Manual.

Most states with rate review laws require that the company provide a qualified actuary’s opinion that the rates are reasonable and comply with state law, as described in model #134. This allows the states to rely on the Code of Professional Conduct and the Standards of Practice that actuaries must follow. In addition, states often look at the whole financial picture of a company when reviewing rate filings.

Most states have different types of prospective or retrospective rate regulation for different comprehensive medical markets, such as individual, small employer, association group, employer-paid, blanket coverage, mini-medical coverage and state/local employee plans.

E. Filing of Rates

Forty-nine states, the District of Columbia and Puerto Rico use the NAIC’s System for Electronic Rate and Form Filing (SERFF) for the filing of rates. While rating rules and policy requirements can differ greatly from state to state, SERFF helps companies by walking them through a checklist of state and federal requirements and then submitting their requests to the states.

III. Rate Increase Disclosure and Review Requirements Under ACA

A. Background

The ACA reorganizes, amends, and adds to the provisions of part A of title XXVII of the Public Health Service Act relating to group health plans and health insurance issuers in the group and individual markets. Section 1003 of the ACA adds a new section 2794 of the PHS Act [42 USCS §300gg-94]. In particular, this section:

1. Directs the Secretary of the Department of Health and Human Services (Secretary), in conjunction with the States, to establish a process for the annual review, beginning with the 2010 plan year, of “unreasonable increases in premiums for health insurance coverage”,
2. Requires health insurance issuers to submit to the Secretary and the State justifications for unreasonable premium increases prior to the implementation of the increases. Requires health insurance issuers to prominently post the submitted justification on their website.
3. Requires the Secretary to carry out a program to award grants to States during the 5-year period beginning with fiscal year 2010 to assist States in reviewing and approving premium increases, and to establish centers to collect medical reimbursement information,
4. For those States that are awarded grants, requires the Commissioner of Insurance to provide the Secretary with information about trends in premium increases and to make recommendations, as appropriate, to the State Exchange about continued participation in the Exchange by an issuer based on a pattern of excessive premium increases,
5. Beginning with plan years beginning in 2014, the Secretary, in conjunction with the States, must continue to monitor premium increases of health insurance coverage offered through the Exchange and outside the Exchange and,
6. In determining whether to offer QHPs in the large group health plans through the Exchange after 2016, States are required to take into account any excess of premium growth outside the Exchange as compared to the rate of such growth inside the Exchange.

On December 23, 2010, the Department of Health and Human Services (HHS) published a Notice of Proposed Rulemaking to implement section 2794. In announcing the proposed rulemaking, the Secretary addressed a letter to Insurance Commissioners stating:

“This proposed regulation recognizes and builds upon the traditional role the states have played in regulating insurance rates and complements existing State-based rate review processes. All proposed rate increases at or above 10 percent would be subject to review, and issuers in the individual and small group markets would be required to provide a justification to both the states and HHS to comply with Section 2794’s requirement that such information be publicly disclosed prior to the implementation of the increase. States with effective rate review programs would review such proposed increases to determine whether they are in accordance with state law. In the small number of states that do not have the legal authority or resources to review rates, HHS would review proposed rate increases of 10 percent or more to determine whether they are reasonable, based on actuarial and other analyses that are currently used by many states to assess rate increases.”

On May 23, 2011, HHS published a final rule with comment period (76 FR 29964), in which HHS specifically solicited further comments on amending the definitions of “individual market” and “small group market” in § 154.102 to include coverage sold to individuals and small groups through associations in all cases.

On September 1, 2011, after consideration of comments, HHS amended the May 23, 2011 final rule to provide that individual and small employer policies sold through associations will be included in the rate review

process, even if a State otherwise excludes such coverage from its definitions of individual and small group coverage.

B. Application of Section 1003 to Issuers, CO-OPs and Multi-State Plans

1. Issuers

Section 1003 applies in the Individual and small group markets. It does not apply to grandfathered health insurance coverage, nor does it apply to self-funded plans. This section will apply to QHPs offered in the Exchange beginning in 2014.

2. CO-OPs

Section 1322(a) of the ACA directs CMS to establish the CO-OP program to foster the creation of member-governed qualified nonprofit health insurance issuers to offer CO-OP QHPs in the individual and small group markets in the States in which they are licensed. The CO-OP program offers low-interest loans to eligible private, nonprofit groups to help set up and maintain health plans. CO-OPs are directed by their customers and designed to offer individuals and small businesses additional affordable, consumer-friendly and high-quality health insurance options.

Starting January 1, 2014, CO-OPs will be able to offer health plans through the Exchanges. In addition to offering health plans through an Exchange, CO-OPs may also offer health plans outside of an Exchange. An Exchange must recognize a health plan offered by a CO-OP if it is deemed certified by CMS or an entity designated by CMS. To be deemed as certified to participate in the Exchanges, the plan must comply with the standards for CO-OP QHPs set forth in the ACA and except for a few narrow exceptions, all State-specific standards established by an Exchange for QHPs operating in that Exchange. Thus, it would appear that Section 1003 will be applicable to CO-OPs offering plans inside and outside the Exchange.

3. Multi-State Plans (OPM Plans)

The ACA authorizes the Office of Personnel Management to enter into an agreement with issuers to offer multi-state plans in the individual and small group markets through the exchanges. OPM must contract with at least one non-profit carrier and the plans offered as a multi-state plan are to be considered QHPs and exchanges must allow them to be offered. However, nothing in the law exempts these multi-state plans from state laws or regulations. OPM is in the process of promulgating regulations relating to these plans.

IV. ACA Rules and Regulations that will Impact How Carriers Price Health Plans and How States Perform Rate Review

The ACA includes several provisions that will affect health plan rating and rate review. Though some of these provisions have already been implemented (and are not explicitly covered below), those with a significant impact on rating will be implemented for plan years beginning on or after January 1, 2014. Rates reflecting these changes will need to be developed and filed by issuers and reviewed by regulators, as applicable, in advance of January 1, 2014, and in the case of QHPs offered through the Exchange, rates will need to be approved, if applicable, prior to open enrollment expected to begin October 1, 2013. Note also that rates for non-grandfathered plans outside the Exchange will also be affected by the ACA market reforms, and that health insurance offered in the outside market may be issuing renewal notices as early as July 1, 2013, for plans effective after January 1, 2014. Therefore, rates will need to be approved months in advance of the October 1, 2013, date for Exchange enrollment.

Issuers and regulators will need to create a process for timely development, submission and review of rates that allows for potential differences between grandfathered and non-grandfathered plans; plans inside and outside the Exchange; and, plans by market if states have varying levels of review authority and effective rate review designations. Delays in implementing rate increases could result in an inadequate premium being charged which could result in higher subsequent rate increases. Additionally, rate review processes and requirements should be consistently applied for multi-state and Co-op plans to maintain a level playing field. Rating and plan accounting will also need to take into consideration new payments and charges to plans, including those for risk adjustment, reinsurance, risk corridors, rebates associated with medical loss ratio requirements, and any new federal or state taxes and assessments. The rating process will also need to account for several potentially significant changes in the market, including covering new populations and benefits, adhering to new rating requirements and underwriting limitations, pooling risks across products within a market (or in some cases across markets), new benefit requirements, and changes in the small group market.

It is clear that the significant number of unknowns that will require issuers to estimate, as well as the interplay of the new elements, present a challenge to issuers and regulators.

Considerations for each of these issues are outlined below.

A. Underwriting Limitations

Issuers will be significantly limited in their ability to deny coverage or charge high premiums to individuals and groups with higher than average health risks. Underwriting provisions in ACA include:

- **Guaranteed availability of coverage (non-grandfathered only):** issuers must accept all individual and employer applicants, limited to open enrollment periods in the individual Exchange.
- **Elimination of medical underwriting for non-grandfathered plans in the individual and group markets**
- **Prohibition of pre-existing condition exclusions**

The impact of these changes on rates and premiums in most markets is expected to be significant. In addition, these provisions could lead to adverse selection if not sufficiently addressed by other provisions in the ACA or required by states.

B. Other Provisions Resulting in Demographic Changes

The ACA includes other provisions that are expected to have an impact on the population covered by health plans. The following provisions are expected to bring new entrants into the health insurance market:

1. ***Establishment of Exchanges:*** Exchanges will provide a mechanism for individuals and small groups to perform more standardized comparisons of available health plan options.
2. ***Individual Mandate:*** Individuals will be required to have health insurance or will pay a penalty, unless they are exempted for religious, affordability, or other allowable reasons.
3. ***Premium Subsidies and Cost-Sharing Reductions:*** For coverage purchased through the Exchange, federal subsidies will be available to individuals and families with household incomes up to 400% of the federal poverty level unless they have affordable minimum essential coverage available to them. Individuals and families with household incomes up to 250% of the federal poverty level will also be eligible for cost-sharing reductions.

4. **Medicaid Expansion:** The significant increase in the number of people eligible for Medicaid under the ACA will impact the demographics of the individual market.

The above provisions coupled with the underwriting limitations and rating requirements are expected to encourage previously uninsured individuals into the health insurance market. The relative health risk and expected cost of this population is a significant unknown. Issuers will need to work with regulators to develop reasonable assumptions related to the expected cost of these new enrollees.

C. Rating Requirements

The ACA also limits rating variations for non-grandfathered plans in the individual and small group markets, to the following:

1. **Geographic Rating Area:** States are charged with defining standard geographic rating areas, subject to approval by the Secretary of HHS. States will need to consider how narrowly to define geographic rating areas to balance affordability and access considerations for individuals in potentially high cost areas. The selection of geographic rating areas may also have an impact on risk adjustment in the state.
2. **Age:** Age factors will be limited to a ratio of 3 to 1 for adults; permissible age bands will be defined by the Secretary of HHS in consultation with the NAIC.
3. **Benefit Coverage:** Guidance with regards to flexibility related to benefit coverage factors has not been provided at the time of this writing. It is unclear, for example, whether benefit coverage factors could account for selection or utilization differences resulting either from group demographics or benefit design.
4. **Family Structure:** Guidance with regards to flexibility related to family structure factors has not been provided at the time of this writing.
5. **Tobacco Use:** Rating for tobacco use is limited to a ratio of 1.5 to 1. Note that HHS is still considering how tobacco use will be accounted for in the risk adjustment model they are developing. Use of tobacco rating factors may also have an impact on the affordability of health insurance. In addition, the most recent IRS regulation on premium subsidies states that the subsidy level will be based on the premium without consideration of any wellness discount or tobacco use penalty.

Note that the rating limitations above apply to large group insured, non-grandfathered plans beginning in 2017 if the state allows large group coverage to be offered through the Exchange.

Under the ACA, a state may further restrict use of rating factors, as long as the state law does not “prevent the application” of the federal law. For example, given that under the IRS regulation tobacco use penalties would not be reflected in the federal subsidy, and that such penalties are difficult to enforce, a state could prohibit rating based on tobacco use.

D. Risk Pools

The ACA also requires issuers to consider all enrollees in non-grandfathered plans within a given market (individual or small group) as part of a single risk pool. Grandfathered plans can be priced in their own risk pool. States also have the option of merging the individual and small group markets into a single risk pool.

States will need to consider how rates should be filed for effective dates starting in 2014. Since there will be a single risk pool in each of the individual and small group markets, states may want to consider how the filing

process may differ from historical methods, including evaluating whether or not all filings will need to be made on a plan basis in the future, or whether issuers may provide a single filing for non-grandfathered rates to reduce duplication.

Additionally, in those states that define small group as groups with 50 or fewer employees, the small group market will be expanded to include groups of up to 100 employees beginning in 2016.

E. Benefit Changes

Issuers of non-grandfathered plans will also need to price for several required benefit changes, including:

1. Coverage of Essential Health Benefits that are expected to be defined at the state level by sometime in the third quarter 2012. Annual dollar limits will not be permitted on Essential Health Benefits.
2. Annual maximum out-of-pocket cost sharing for plan years beginning in 2014 will be limited to those in effect for health savings accounts in that year.
3. Deductibles in small group plans will be limited
4. Non-grandfathered plans in the individual and small group markets (both inside and outside the Exchange) will need to meet actuarial value requirements such that each plan fits into a metal level of coverage (bronze, silver, gold, or platinum), except for the catastrophic plans offered to certain enrollees.

Note that states may need to engage their actuaries as part of the form review process, to validate actuarial equivalence for benefit substitutions as defined in EHB guidance, along with verification of a plan's metal level.

F. Risk Mitigation Programs (Three Rs)

In order to mitigate selection and pricing risk for issuers, the ACA includes implementation of three risk mitigation programs. First is a temporary reinsurance program which reimburses non-grandfathered individual plans, both inside and outside the Exchange, for a portion of the cost of high cost enrollees. The aggregate amount of reinsurance payments will be fixed at a state level at decreasing amounts over three years (2014 through 2016). Second is a permanent risk adjustment program which will transfer funds from non-grandfathered individual and small group plans with a lower than average risk population to such plans with a higher than average risk population. The risk adjustment program will be budget neutral within each market (individual and small group) at the state level. Third is the federal risk corridor program.

The risk adjustment program is designed to equalize risks across plans within each applicable market. As a result, theoretically, all issuers should price their non-grandfathered individual and small group plans assuming they get an average risk population. In practice, however, risk adjustment is not perfect and does not account for all selection differences across plans. In addition, given other ACA changes, there is significant uncertainty related to what an average risk population will be, especially in the individual market. Once the market stabilizes and relative health risks across issuers are better known, plans should be able to price their plans based on anticipated risk adjustment payments and charges.

In the meantime, issuers will need to work with regulators to develop reasonable assumptions related to the impact of anticipated population changes in 2014. This pricing risk, based on high levels of uncertainty in the individual market, is intended to be addressed by ACA's third risk mitigation program, risk corridors. In this program, issuers participating in the individual and small group markets will be limited in their level of gains and losses for their QHPs in calendar years 2014 – 2016. Specifically, HHS will reimburse QHPs 50% of the difference

between allowable costs and a target amount for differences between 103 and 108 percent, and an amount equal to the sum of 2.5% of the target amount and 80% of allowable costs in excess of 108 percent of the target amount. Conversely, HHS will charge 50% of the difference between allowable costs and a target amount for differences between 92 and 97 percent and an amount equal to the sum of 2.5% of the target amount and 80% of allowable costs less than 92 percent of the target amount. Risk corridors will be applied after reinsurance and risk adjustment. Issuers and regulators should consider the impact of risk corridors in determining reasonable levels of margin to include in rates for 2014 – 2016, as well as rate adequacy given the program subsidizes losses. Issuers and regulators will also need to consider the interaction of the risk mitigation programs with the calculation of MLR rebates.

G. Medical Loss Ratio Requirements

The ACA requires issuers to provide rebates to consumers if certain minimum medical loss ratios are not met. Those ratios are, generally, 80% for the individual and small group markets and 85% for the large group market. A state may choose a higher level and several states have applied for and received adjustments that lower the ratio in the initial years (this applies to the individual market only). This requirement became effective calendar year 2011, with rebates paid by August of subsequent years.

Though the medical loss ratio requirement in ACA is a retroactive standard, some issuers may want to address the requirement prospectively in their rating to mitigate the risk of having to pay rebates. Note, however, that the MLR is calculated on a statewide aggregate level by segment, whereas rates are often at the plan level (and will be at the plan level of QHPs). Thus, some care should be taken when incorporating the MLR requirement into the rate review process and standards.

H. New Federal Taxes and Fees

Under the ACA, health issuers will be required to pay new annual issuer taxes and fees beginning in 2014. Health issuer excise taxes, calculated based on issuers' market share and using the previous calendar year premium as a proxy, are prescribed in the ACA as follows:

Year	Amount (Billions)
2014	\$8
2015	\$11.3
2016	\$11.3
2017	\$13.9
2018	\$14.3
After 2018	Increased by premium growth

In addition, the non-deductible nature of the excise tax will require issuers to build in more than the actual fee amount into their premiums.

Other new fees or assessments that will likely be charged to health issuers include: Exchange user fees; the reinsurance program assessment benefitting the individual market (totaling \$25 billion from 2014-2016); the Patient Centered Outcomes Research Institute (PCORI) fee; and, in 2018, the excise taxes on high value health insurance that will apply in some cases.

I. Rating Inside and Outside the Exchange

Issuers offering QHPs in the Exchange must offer the “same premium rate” for plans offered inside and outside the Exchange and whether they’re sold directly or through an agent. It is unclear what steps regulators will need to take to validate that this requirement is being met. States may want to consider establishing a process that requires issuers to submit plan filings in the same manner both inside and outside the exchange.

The ACA includes additional rate review requirements for QHPs offered through the Exchanges. Exchanges are required to consider the following as part of QHP certification:

- A justification for a rate increase prior to the implementation of the increase;
- Recommendations provided to the Exchange by the State as required under the premium review grant program; and
- Any excess of rate growth outside the Exchange as compared to the rate of such growth inside the Exchange.

States with premium review grants are required to make recommendations to Exchanges regarding whether particular health issuers should be permitted to offer plans on the Exchange. This recommendation is based on a “pattern or practice of excessive or unjustified premium increases” and information regarding premium growth rates inside and outside of the Exchange. States that have not received a premium review grant can, of course, make the same recommendation to the State-Based Exchange or the Federally Facilitated Exchange.

It is unclear at the time of this writing whether there will be a specific format for Exchange rate increase justifications, and whether those justifications need to be at a QHP level of detail, or some higher level (e.g., product or market). Concern exists over the granularity and credibility of the data should the justifications be required at the QHP level. Exchanges and regulators will also need to consider the measures to determine excess of rate growth outside the Exchange.

It is also important to note that issuers wishing to participate in Exchanges will need to submit plan level data as part of the QHP certification process. Some states may choose to review rates at the plan level outside the Exchange as well to ensure consistent processes across the markets. In addition, plans outside the Exchange will also need to meet the actuarial value requirements. If states review actuarial values consistently inside and outside the Exchange, plan level data may need to be collected for the non-Exchange plans as well as the Exchange plans.

J. Small Group Considerations

The ACA has a specific definition of small group that might not be consistent with current state definitions. For example, the ACA counts employees using an average of the total number of employees on business days during the preceding calendar year, whereas some states may count only full time employees, or use some other counting method. Additionally, the ACA does not treat sole proprietors with no employees (other than a spouse) as small groups, which differs from their treatment in some states.

The ACA definition applies to participation in the Small Business Health Options Program (SHOP) and calculation of the Medical Loss Ratio. States might consider aligning their definition of small group with that of ACA to avoid any confusion in the market.

Another consideration in the small group market is the ability to set group-level rates in an employee choice model provided through the SHOP Exchange. It is unclear how group rates would be determined in an environment where employees of a given employer can select multiple plans from multiple issuers.

K. Rating of Grandfathered Plans

The ACA provides for the grandfathering of health insurance plans in which an individual was enrolled or was offered to a group on March 23, 2010. While some provisions of the ACA do apply to grandfathered plans (e.g., MLR requirements, elimination of lifetime limits), the rating and benefit requirements, and many of the underwriting provisions above do not apply. The ACA also prohibits states from requiring that grandfathered plans be pooled with non-grandfathered plans for rating purposes. Grandfathered plans are also not subject to the premium review disclosure requirements.

States will need to consider how to review rates for grandfathered plans. Grandfathered plans are not open to new groups or individuals. Because different coverage and rating rules apply to grandfathered plans, states may want to consider requiring separate filings for grandfathered vs. non-grandfathered plans.

L. Multi-State Plans and Co-Ops

The ACA directs the Secretary of the Office of Personnel Management (OPM) to enter into contracts with health issuers (at least one must be a non-profit) to offer at least two multi-State QHPs through each Exchange in each state. It does not appear that multi-State plans will go through the same certification process required by other plans offered through the Exchange. However, nothing in the ACA exempts multi-state plans from state laws or regulations.

The ACA also establishes Consumer Operated and Oriented Plans (Co-Ops) to *foster the creation of qualified nonprofit health insurance issuers to offer QHPs in the individual and small group markets in the States in which the issuers are licensed to offer such plans*. In states where Co-ops are established, they are required to be offered on the Exchanges and comply with all Exchange rules and other state laws and regulations.

The ACA requires a level playing field across health issuers, including multi-State and Co-Ops. Specifically, the ACA states, that *health insurance coverage offered by a private health insurance issuer shall not be subject to any Federal or State law... if a qualified health plan offered under the Consumer Operated and Oriented Plan program under section 1322, or a multi-State qualified health plan under section 1334, is not subject to such law*.

There is nothing in the ACA that would preempt state laws and regulations for CO-OPs or multi-state plans. OPM has not yet published proposed regulations for the multi-state plans, but the NAIC has stated in a letter to OPM that multi-state plans will be required to comply with all state laws and regulations.

M. Stand-Alone Dental Plans

The ACA specifically states that stand-alone dental plans may be sold through the Exchanges. These plans must offer pediatric dental services, which are included as a required Essential Health Benefit in the ACA. States will need to decide how rates for these plans will be reviewed and what rating rules will apply to them.

N. Wellness Program Discounts

In section 2705 of the ACA, premium discounts for participation in wellness programs are allowed if they meet the criteria set forth in the Public Health Service Act. How these discount programs interact with rating factors and their impact on the cost of coverage based on health should be considered by the states.

In addition, the most recent IRS regulation on premium subsidies states that the subsidy level will be based on the premium without consideration of any wellness discount or tobacco use penalty.

V. Individual and Small Group Rate Review under the ACA

A. State Rate Review

1. *Reporting of Certain Rate Increases*

Prior to establishment of an Exchange, all issuers must submit rate increases in excess of the rate review threshold established in each state (currently set at 10% in every state) to the federal Health Information Oversight System, or HIOS. This requirement applies to all non-grandfathered products. States with Effective Rate Review programs will review the rates and determine whether rates are considered unreasonable. This determination and associated justification must be reported in HIOS. States that are determined to not have an Effective Rate Review process will have those rate increases reviewed by HHS, though HHS has no authority to deny a rate increase.

Beginning in 2014, all QHPs in the Exchange will be required to report any rate increase to HIOS. Plans outside of the Exchange will only be required to report increases that exceed the threshold established in each state.

Under a state based system, it is assumed that the reasonable or unreasonable determination will be consistent with the state's own approval process. For example, if a state approves a filing, it will also find the rates to be "not unreasonable."

States receiving rate review grants have additional reporting requirements through HIOS. These include quarterly reports of the activity associated with the rate review grants, periodic conversations with CMS staff, and quantitative reports showing patterns of rate increases. SERFF has provided an interface with HIOS to allow states using SERFF to seamlessly report the rate activity in their quarterly HIOS reports.

2. *Geographic Regions and Age Bands*

States must report to HHS the proposed rating areas established for the individual and small group markets under Section 2701. If a state does not establish the rating areas or HHS deems the rating areas inadequate, HHS will determine the rating areas for the state.

Section 2701 allows individual and small group issuers to rate based on age provided that the age rates do not vary by greater than a 3 to 1 for adults. Age bands are required and the selected age bands must be approved by HHS after consultation with the NAIC. The Health Actuarial Task Force has been working to develop guidance to HHS regarding the establishment of age bands.

As these provisions apply to products sold both on and off the Exchange, states along with the NAIC should endeavor to establish the rating areas and age rating bands by the end of 2012 to provide adequate time for issuers to establish and submit rates for approval, both under state rating laws and as part of the QHP submission process. Time is critical: some issuers will need to submit rate filings as early as October 2012 in order to obtain approval by July 2013 for January 1, 2014, effective dates.

3. Consumer Disclosure

Per Section 154.301, states with Effective Rate Review must post to its website Parts I and II of the Preliminary Justifications and provide a means for comments to be submitted on any proposed rate increases that exceed the state rate review threshold. CCIIO has encouraged states to provide links to the Consumer Disclosure forms on Healthcare.Gov rather than posting the Preliminary Justifications on their websites to ease the burdens on states to update the files on their own websites.

This process could be used to notify the Exchange of rate increases exceeding the state threshold. In addition, the website could be used to post rate increases for all QHPs to allow the Exchange to access all rate changes as part of their requirement to review patterns of rate increases. States should consider all options to communicate rate increases to the Exchange, especially those that leverage current processes and minimize duplicative effort.

4. General Rate Review Items

States will be motivated to maintain their “Effective Rate Review Program” status as it will be a sign to consumers that the state has a transparent premium oversight process and it will avoid the additional regulatory burden on health Insurance carriers of having to undergo both a state and federal rate review process.

The American Academy of Actuaries has stated that effective premium oversight should be based on the following actuarial principles: health insurance premiums must be adequate to pay projected claims, expenses, and supporting risk charges; premium oversight should be done in conjunction with issuer solvency oversight; premium oversight requires strong actuarial representation; appropriate risk-based capital (RBC) levels must be in place; premiums should be self-supporting and not subsidized by other lines of business; the premium-review process should be transparent and equitable for all issuers; the premium-review process should allow for adequate premiums that appropriately reflect past experience; and the premium review process needs to be coordinate between state and federal regulatory entities.¹

There are 13 areas of necessary review that are defined in the “Effective Rate Review Program” (45 CFR 154.301(a)(4)). One thing to keep in mind is that even if a state already reviews these items for reasonableness, they will now be required to examine the validity of the historical data underlying the assumptions used in rate development (45 CFR 154.301(a)(3)) and are expected to review the emerging actual experience in relation to the expected of each carrier as part of the rate review process (45 CFR 154.301(a)(3)). For many states, this will result in a more in depth actuarial review than they have performed previously.

a) The impact of medical trend, cost and utilization, and cost-sharing changes by major service categories

Since trend, cost and utilization, and cost-sharing will usually have the most material impact on proposed rates, this will be where the majority of the time is spent in the rate review process.

States will need to perform trend analysis broken down by the required major service categories, and by unit cost vs. utilization pursuant to 45 CFR 154.301(a)(3). The medical trend will be analyzed at a more

¹ American Academy of Actuaries Premium Review Work Group comment letter to HHS regarding Section 274 of the PHSA May 14, 2010

aggregate level, such as class of business. Carriers need to submit the data used to develop the trend assumptions, prior projections of trend assumptions, and the actual trend realized in recent periods. In short, pricing actuaries are expected to report how well previous actuarial assumptions have compared to actual experience, and the basis for their current actuarial assumptions. This new requirement might be something that state regulators are not accustomed to.

If there have been cost-sharing changes, carriers will need to show how the experience used for rate development has been adjusted and disclose the impact of the change. These disclosures could come in the form of changes in plan actuarial values or plan benefit factors.

b) The impact of benefit changes

Along with the impact on rates, carriers will need to show that they have adjusted the experience used in rate development. State regulators will need to be able to check that the effect of benefit changes hasn't been double counted (once in the trend and again in the factors).

c) The impact of changes in enrollee risk profile

Carriers will be required to submit sufficient information to demonstrate that historical experience has been adjusted to reflect the anticipated enrollee risk profile.

d) The impact of any overestimate or underestimate of medical trend for prior year periods related to the rate increase

Disclosing the impact of any overestimate or underestimate of medical trend for prior year periods related to the rate increase may help delineate what part of the rate increase request may be attributable to a prior misestimate. It should be noted that trend is calculated at an aggregated level and shouldn't differ by plan (with the exception of deductible leveraging). By breaking this out, this will help the regulator better judge the reasonability of the filed rates.

e) The impact of changes in reserve needs

Reviewing the impact of changes in reserve needs will consist of a review of the completion factors used in reserve development. Regulators might want to evaluate the historical adequacy of the claim reserve by having carriers disclose how prior periods claim reserve compares with the actual claims paid. Regulators also might want to monitor the change in completion factors as this can skew trend estimations.

f) The impact of changes in administrative costs related to programs that improve health care quality and other administrative costs

Requesting that administrative costs related to programs that improve health care quality and other administrative cost be categorized in accordance with the federal MLR guidelines will allow states to monitor the overall MLR level as defined by HHS. However, since some states have MLR targets that are independent of the federal guideline MLR requirement, they might choose to use their own reporting categorizations and definitions.

g) *The impact of changes in applicable federal taxes, licensing or regulatory fees*

Carriers should submit actual taxes, licensing or regulatory fees for a period corresponding to the base period used for claims experience as well as those anticipated during the projected period. If historical taxes, licensing and fee ratios vary materially from those used in pricing, an explanation should be given.

h) *Medical loss ratio*

Carriers should ensure their filed rates comply with applicable minimum medical loss ratio (MLR) requirements. Many states have established minimum MLRs on a prospective basis, often calculated as the present value of benefits divided by the present value of premiums. The federal government through the ACA has established a retrospective standard for minimum MLRs (see Section IV, item G). States should continue to enforce the state standards.

Some states have chosen to incorporate the federal minimum MLR requirements in their rate review process, thereby applying the federal standard on a prospective basis. It should be noted that a retrospective credibility adjustment should not be applied to a prospective loss ratio.

States that do not require carriers to price to the retrospective federal MLR may wish to have carriers state their intention to comply with the federal minimum MLR rebate requirements. States may also wish to request carriers provide an estimate of the federal MLR as further demonstration of anticipated compliance and to ensure that the range of potential rebates is reasonable.

i) *The health insurance issuer's capital and surplus*

Capital and surplus levels are already included in financial statements filed with the state, therefore some states do not require carriers to include this in their rate filings.

j) *Allowed case characteristics and community rating*

The allowable case characteristics that are permitted in rate filings have varied historically state-by-state. Starting in 2014, all states will adopt modified community rating with the following set of allowable case characteristics:

- Geographic rating areas;
- Age;
- Family size/composition; and
- Tobacco use.

States will need to verify that the variation in rates created by each case characteristic complies with federally mandated ratios.

k) *Risk Adjustment*

As a result of guaranteed issue and community rating requirements, there will be increased adverse selection and carriers will have a decreased ability to vary premiums to appropriately reflect the specific risks they are insuring. In response to this, a risk adjustment mechanism will be implemented in 2014.

A risk adjustment mechanism will need to be calibrated so that it can financially compensate (or charge) carriers when the risk of their block of business is greater (or less) than the average risk in the market in a state. As a result, carriers will need to price their business based on the average risk pool of the state market rather than the average risk pool of their own block of business. It is not clear what tools or information will be given to carriers in order for them to be able to do this.

Further complicating the matter, any risk adjustment algorithm, no matter how good, will not perfectly compensate carriers for the risk of their member populations. As a result, carriers might add a degree of conservatism to their rates until they understand how the risk adjustment mechanism will affect their financial results.

State regulators will need to be aware that rate filings will include an adjustment for the carriers' expected risk population compared to the expected average market risk, plus potential short-comings of the risk adjustment program.

It should be noted that the risk adjustment program, as envisioned by HHS, will be based on *relative*, not *absolute*, risk, so it will be virtually impossible for any carrier to assess its relative risk in the first year of operation of the risk adjustment program, and possibly longer given the timeframes for filing rates, timeframes for risk adjustment settlement, and data audit adjustments.

l) Temporary Risk Mitigation Programs

Starting in 2014 and lasting for three years, a reinsurance and risk corridor program will be in place to help stabilize the market.

i. Reinsurance

Reinsurance will affect pricing since a charge will be assessed against all market participants. Some might assume that overall the effect will be neutral since premiums should roughly equal claims. However, if reinsurance premiums collected are less than claims covered, then the reinsurance pool won't be able to pay all reinsured claims. Because of this risk, it is possible that carriers will not treat reinsurance as revenue neutral, but will add an extra margin to their pricing to cover the added cost risk. This is due to the fact that the "premium" being paid into the reinsurance pools will be made by those in the small group, large group, self-insured and individual markets, while the "claims" will be reimbursed only in the individual market. The effective in each market is not neutral, even if the total premium equals total claims.

ii. Risk Corridor

The risk corridor likely wouldn't affect pricing or rate review of filings, at least initially.

m) Small Group – list bill vs. composite rating

As this relates to the manner of billing rather than rating or pricing one might reasonably expect that it would not affect the rate review.

5. Coordination of Regulatory Efforts with Exchange

a) Coordination of Frequency of Review

In an effort to minimize the regulatory burden on issuers and to promote efficient Exchange management, the Plan Management functions should generally be performed by the state's insurance department to the extent they have familiarity with and authority to perform the rate review function under Plan Management. Many states require annual filings for rates and for those states we would recommend that the QHP rate review be coordinated with the issuer's annual rate filing. To the extent issuers submit rate filings less than annually, the Exchange, in coordination with the state insurance department, should request premium renewal information from the issuer for purposes of evaluating patterns of rate increases.

b) QHP's

Per Section 155.1020, an Exchange must receive justification for rate increase for a QHP prior to implementation. It is expected that Exchanges will leverage existing regulatory mechanisms to meet the Rate Review requirements under Plan Management.

c) *Recommendations provided to the Exchange by the State in accordance with section 2794(b)(1)(B) of the PHS Act*

Section 2794(b)(1)(B) requires the state's insurance commissioner to make recommendations, as appropriate, to the Exchange about whether particular health insurance issuers should be excluded from participation in the Exchange based on a pattern or practice of excessive or unjustified premium increases. This provision explicitly involves the state insurance commissioner and therefore we recommend that states develop a process to review issuers' history of rate increases and make recommendations to the Exchange. We believe it is appropriate for state regulators to perform this analysis and report to the Exchange on an annual basis unless the Exchange requests an interim review due to a recent pattern of rate increases.

6. Other Considerations

a) SERFF

The NAIC has established a project to build out the required Plan Management functions through SERFF, at the request of the members. Proposed key functions to support rate review include navigation between rate/form filings and plans, managing plans within SERFF, communication and correction of issues by issuers, and state certification of plans according to state specific needs. A key component for rate review is the navigation function, which will permit SERFF users to leverage tie plan filings to existing or new forms and rates filed and approved with the state to satisfy the related components of the QHP review and certification process. The remaining components provide states and issuers with the necessary interface to manage and communicate issues, similar to the current SERFF functionality for rate and form filings.

The SERFF implementation team expects the release of the QHP management module to occur in December 2012, with the functionality for renewal and decertification to follow in the 2nd and 3rd quarter 2013. The Plan Management functions in SERFF are support an exchange regardless of format (i.e., state-based, partnership or full federally facilitated).

b) *New vs. Existing Plans*

The QHP certification process will be applied to all plans seeking QHP status on the Exchange effective January 1, 2014. This will include both the review of any rate increase as well as the evaluation of patterns of rate increases as required under Section 2794. Once the Exchange has been established, new plans would be expected to follow the same process applied to plans seeking QHP status on January 1, 2014. Existing plans will have the same requirements but states can leverage prior evaluations of rate increase patterns to minimize the regulatory effort.

c) *Grandfathered Plans*

As grandfathered plans cannot be offered on the Exchange, it is expected the regulatory burden for grandfathered plans to be significantly less than non-grandfathered plans – for example, grandfathered plans are not subject to the federal rate review process. However, states should understand the size and composition of insureds remaining in grandfathered plans to understand the potential adverse selection effects on Exchange business. Also, states may apply the same rate review requirements on grandfathered plans.

Due to the numerous triggers resulting in the loss of grandfathered status, it is expected that the number of grandfathered plans will diminish significantly over time.

d) *Catastrophic Plans*

Section 1302(e) allows issuers to offer catastrophic-type plans to individuals under the age of 30 that meet certain affordability or hardship standards. The plans will cover essential health benefits but will include deductibles equal to the amounts specified as out-of-pocket (OOP) limits for HSA-qualified HDHPs.

Since catastrophic plans are considered QHPs, the rate review requirements under QHP certification will apply equally to catastrophic and metal level plans.

e) *Funding/Resources*

Federal Rate Review Grant funds have been made available to states for the purpose of upgrading rate review processes to meet the minimum federal standards for an effective rate review process. However, the continued availability of these funds is not guaranteed and, in fact, unlikely. As states consider enhancing rate review standards and processes the need for additional resources, and the sources of funds to cover those costs, need to be taken into consideration.

B. Federal Rate Review

1. Authority

Section 42 USC 300gg-94 of the ACA requires the Secretary, in conjunction with States to establish a process for the annual review of unreasonable rate increases in premiums for health insurance coverage. The ACA requires health insurance issuers to submit to the Secretary and the relevant state insurance departments, a justification for a premium increase over the threshold amount prior to the implementation of the increase.

On May 19, 2011, the Center for Medicaid and Medicare Services (CMS) issued the final regulation on Rate Increase Disclosure and Review Requirements. Pursuant to the regulation, CMS must determine if a state has effective rate review authority over health insurance. In 45 CFR 154.301, the criteria for determining whether or not a state has an effective rate review program includes receipt of data and documentation sufficient to make the justification determinations required by federal law; timely and effective review of the reasonableness of assumptions; and effective review of the impact of changes to medical trend, utilization, cost-sharing, benefits, risk profiles, reserve needs, MLR and other information relating to administrative costs. In addition, the state's reasonableness determination must be made under a standard set forth in state law or regulation, and the state must provide public access to Preliminary Justifications.

If CMS determines that a state does not have "an effective rate review program," CMS will perform the review of rate increases equal to or greater than 10 % or any other "state-specific threshold" identified in later years. In 2011, CMS identified seven states that had ineffective rate review authority or no rate review authority, in whole or in part, over rates in the individual and small employer group non-grandfathered major medical health insurance market. CMS conducts the review of rate increases over 10% pursuant to 45 CFR Part 154 in those states.

When reviewing rate increases for an "ineffective" state, if CMS finds that a particular rate increase is "unjustified," "excessive," or "unfairly discriminatory," it will make a public announcement of that finding, post it on the CMS website, and require the health issuer to post that finding on its website as well. CMS does not have the authority to "disapprove" a rate increase or prohibit an issuer from using the rate that it found to be unjustified. [45 CFR 154.205; 45 CFR 154.225]

An issuer may choose to reduce its rate increase below the 10% and avoid the publicity. If the issuer lowers its rate increase, but not below the threshold, it must submit a new Preliminary Justification and CMS will review it again. If a health issuer implements a rate increase determined by CMS to be "unreasonable," the issuer must submit a "Final Justification" to CMS that responds to the unreasonable rate increase determination and the health issuer must post the finding on its website. The information in the final justification must be consistent with the information filed in the Preliminary Justification. [45 CFR 154.230]

2. Federal Reporting Requirements

Beginning September 1, 2011, all non-grandfathered small employer group and individual market health insurance rate increases that are 10% or more (state specific thresholds may change in subsequent years), must be reported to the Secretary and the state insurance department, if that department has an effective rate review program. CMS will defer to the State's determination of reasonableness in states that CMS has determined to have an effective rate review program. [45 CFR 154.210] In states that do not have effective rate review, all rate increase information required to be reviewed under the regulation is filed with the Secretary through HIOS. CMS has actuaries on staff and under contract who review those rate increases. CMS will share information and discuss its review with the "ineffective" states, if the state insurance commissioner requests that information.

Health insurance issuers must submit to the Secretary a "Preliminary Justification" for each product affected by the increase on a form prescribed by the Secretary that contains the following information: the rate increase summary (Part I), a written justification of the rate increase (Part II) and rate filing documentation (Part III). An "ineffective" state can require that Parts I and II also be filed with its insurance department. However, Part III is sent to CMS only. A single, combined Preliminary Justification can be sent for multiple

products, if the claims experience of all products has been aggregated to calculate the rate increases and the rate increases are the same for all those products. The detailed content of Parts I, II and III is described in 45 CFR 154.215.

3. *Consumer Disclosure*

CMS posts Parts I and II of all Preliminary Justifications on its website. State Insurance Departments must also post this information on their websites.

The Preliminary Justification contains a rate increase summary (Part I) and the written description justifying the rate increase (Part II). The rate increase summary must include historical and projected claims experience, trend projections related to utilization, any assumptions related to benefit changes, allocation of premium increase to claims and non-claims cost, per enrollee per month allocation of current and projected premiums, and a three year history of rate increases for the product. The written description justifying the rate increase must include a simple and brief narrative describing the data assumptions used, including an explanation of the most significant factors causing the rate increase and a brief description of the overall experience of the policy, historical and projected. Part III of the Preliminary Justification contains documentation supporting the rate increase. Part III information will be posted only to the extent that it does not contain trade secrets or is otherwise confidential. CMS enables the public to comment on the Preliminary Justifications. [45 CFR 154.215]

CMS posts its determination and a brief explanation of its findings on its website. State insurance departments may also post the information. The health insurance issuer is legally required to prominently post on its website the information relating to CMS's determination of "unreasonable," if the issuer chooses to implement a rate increase determined to be unreasonable by the state or CMS. The issuer must also include its "Final Justification" for implementing the increase despite the unreasonable determination. The health insurance issuer must keep this information on its website for at least three years. [45 CFR 154.230]

4. *Coordination with and Role of the States*

CMS will coordinate its review with state insurance departments that have been determined to be "ineffective," if that state has some authority to review or investigate health insurance rates and is interested in being involved with the federal effort to implement and enforce the Health Insurance Issuer Rate Increases: Disclosure and Review Requirements regulations. State Insurance Department involvement may benefit consumers and assist with public disclosure.

VI. Exchange QHP Review

A. State Based Exchange

1. *Authority*

The ACA authorizes each state to establish an American Health Benefit Exchange (Exchange) by no later than January 1, 2014 for the purpose of facilitating the purchase of “QHPs.”² The Exchange is only authorized to offer health plans which are certified as QHPs.³

2. Rate Review

a) QHP Certification

The ACA requires the Secretary of HHS to promulgate regulations to “establish criteria for the certification of QHPs.”⁴ It also authorizes an Exchange to certify health plans as QHPs (QHPs) if they meet certain requirements, including those specifically established by the Secretary through regulation.⁵ A health plan may be certified as a QHP if the health insurance issuer demonstrates compliance with the minimum certification requirements stated in the regulations.⁶

Health plans seeking certification as QHPs must (1) “submit a justification [to the Exchange] for any premium increase prior to implementation of the increase” and prominently post the justification on their websites⁷ and (2) agree to charge the same premium rate for each QHP it offers, regardless of whether the plan is offered through an Exchange or in the outside market.⁸ Exchanges are specifically required to take the justification information submitted by health plans, along with information and recommendations provided by a State related to patterns of excessive or unjustified rate increases, into consideration when determining whether a particular health insurance issuer’s plan(s) should be offered through the Exchange.⁹ The Exchange is also required to consider information reported by a State regarding “any excess of premium growth outside the Exchange as compared to the rate of such growth inside the Exchange.”¹⁰

b) Degree of overlap or independence with State DOI

As stated above, Exchanges are specifically required to take information and recommendations provided by a State’s insurance regulator when determining whether a health plan should be available on the Exchange. HHS encourages Exchanges to minimize the potential burden on QHP issuers by leveraging the existing State rate review processes, including adopting the format currently being used

² ACA § 1311(b), 42 USC § 18031(b)

³ 45 CFR § 155.1000

⁴ ACA § 1311(c), 42 USC § 18031(c)

⁵ ACA § 1311(e), 42 USC § 18031(e)

⁶ 45 CFR § 155.1000

⁷ ACA § 1311(e), 42 USC § 18031(e); 45 CFR § 155.1020

⁸ ACA § 1301(a), 42 USC § 18021(a)

⁹ ACA § 2794(b), 42 USC § 300gg-94(b); 45 CFR § 155.1020

¹⁰ ACA § 1311(e), 42 USC § 18031(e); 45 CFR § 155.1020

by health issuers for the submission of rate justifications to States,¹¹ but does not specifically prohibit Exchanges from conducting additional review of rate increases.¹² However, it is noted that an Exchange's consideration of rate increases is limited to determining whether a QHP should be offered on the Exchange.¹³ It is also important to note that the requirement for a QHP to post a rate increase justification on its Web site is required regardless of whether the increase is considered an "unreasonable increase" and subject to review by a State.¹⁴

c) *Comparison of rates and growth of rates inside and outside the exchange.*

As stated above, an Exchange is also required to consider information regarding excess premium growth outside the Exchange as compared to the rate of such growth inside the Exchange when considering the rate increase justifications submitted by QHPs. HHS notes that information about rates and rate increases for similar health plans being sold outside of the Exchange may be helpful in this process.¹⁵

d) *SERFF*¹⁶

In the fall of 2011 NAIC staff began discussions with HHS officials regarding the potential use of the existing SERFF system as a tool for States to use when performing rate review functions associated with the certification of QHPs. The NAIC created a SERFF Plan Management Technical Study Group (TSG) to define the business requirements for the SERFF Plan Management project, with a focus on the capabilities that will be needed in early 2013 when issuers begin to submit their plans for QHP certification. These critical capabilities include: 1) creation and submission of plans by issuers; 2) review functions for approval and certification by the states and Exchanges; and 3) the ability to share plan data among Exchange-related software applications. Work to implement these functions will continue throughout 2012 and will be available to States for use in 2013.

While the SERFF development team has been working on modifications to support Plan Management functionality related to Exchanges, SERFF will separate the code for the Plan Management portion of SERFF to greatly reduce the possibility of impacts to non-Plan Management SERFF customers. Users will sign in to SERFF with the same user ID and password they have today with the intent of presenting a look and feel consistent with the current SERFF user interface as the additional QHP-specific screens are developed. As with other aspects of SERFF, only the users who need to see and work with the additional Plan Management features will see the associated options in SERFF.

¹¹ ACA § 2794(a), 42 USC § 300gg-94(a)

¹² Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, 77 Fed. Reg. 18,310, 18,407 (March 27, 2012).

¹³ Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, 77 Fed. Reg. 18,310, 18,408 (March 27, 2012).

¹⁴ 45 CFR § 156.210; Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, 77 Fed. Reg. 18,310, 18,416 (March 27, 2012).

¹⁵ 45 CFR § 155.1020; Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, 77 Fed. Reg. 18,310, 18,408 (March 27, 2012).

¹⁶ NAIC HIX Bulletin, Issue 4, April 30, 2012

3. Coordination with State DOI

a) Effective Rate Review States vs. States Without Effective Rate Review Status

Although the regulations issued by HHS to date do not provide clear guidance regarding the role of States that do not have an “effective rate review program” as it relates to Exchanges, these States may still have an obligation to assist Exchanges in meeting their QHP rate justification requirements. HHS has stated that CMS will determine whether rate increases subject to review under Sec. 2794 of the ACA are “unreasonable” unless a State has an effective rate review program.¹⁷ However, Sec. 2794 also requires States that have been awarded Premium Review grants to make recommendations to Exchanges regarding whether particular health issuers should be permitted to offer plans on the Exchange based on a “pattern or practice of excessive or unjustified premium increases” and information regarding premium growth rates inside and outside of the Exchange. Exchanges are required to take such recommendations into consideration.¹⁸

b) Coordination of Frequency of Review

Health issuers offering QHPs in an Exchange must: (1) submit information on rates at least annually in a manner and form specified by HHS; (2) set rates for an entire benefit year or SHOP plan year; and (3) submit justification for any rate increase prior to the implementation of the increase.¹⁹

During the comment period for the Exchange regulation some commenters expressed concerns about the requirement to set rates for an entire benefit or plan year because of the possible need to establish new rates, quarterly or annually, to accommodate Federal or State regulatory changes. HHS declined to make an exception to the “entire year” rule because it determined that such regulatory changes are generally known to issuers well in advance and it believes the number of changes that would take effect in the middle of a benefit or plan year would be limited.²⁰

c) Recommendations provided to the Exchange by the State in accordance with section 2794(b)(1)(B) of the PHS Act

See comments above.

4. Federal Reporting Requirements

a) HIOS

As addressed in other sections of this White Paper, the ACA requires States that receive Premium Review grants to provide quarterly reports to HHS, through the Health Insurance Oversight System (HIOS), regarding the number of rate filings received and reviewed, number requesting an increase, and

¹⁷ 45 CFR § 154.210

¹⁸ ACA § 2794(b), 42 USC § 300gg-94(b); ACA § 1311(e), 42 USC § 18031(e).

¹⁹ 45 CFR § 155.1020; 45 CFR § 156.210

²⁰ Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, 77 Fed. Reg. 18,310, 18,416 (March 27, 2012).

number approved, denied or deferred.²¹ States must also provide specific information about each filing, including the identity of each insurance company submitting a filing and the type and amount of the requested rate change. In addition, States that have an effective rate review program are also required to provide CMS with a final determination of whether a requested rate increase is unreasonable, which must include a brief description of its analysis of the rate filing and how it arrived at its determination.²²

b) Other Reporting Requirements

In addition to the general rate review requirements, as stated above, States have specific reporting obligations related to Exchanges, including information related to “patterns or practices of excessive or unjustified premium increases” and information about the growth rate of premiums both inside and outside the Exchange.²³

5. Consumer Disclosure

As stated above, all QHP issuers are required to submit to the Exchange a justification for all rate increases prior to their implementation and to prominently post these justifications on their Web sites.²⁴

6. Funding

Exchange Establishment Grant funds are available for states through 2015. These funds may be used to cover costs of establishing a State-Based Exchange, including upgrading systems and processes for rate review. However, funding for the on-going operation of the Exchange is a responsibility of the states. DOIs that will be performing additional functions for the Exchange will need to ensure additional costs are covered.

B. Partnership Exchange²⁵

1. State Partnership with Federally Facilitated Exchange

In guidance issued in May 2012, HHS provided some insight into how a federal/state partnership may work. In such an arrangement, HHS would retain full authority and responsibility for the Exchange as a Federally Facilitated Exchange, but the states could choose to fulfill the Plan Management and/or Consumer Assistance functions of the Exchange.

In the May 2012 guidance, the various functions are broken down as follows:

²¹ ACA § 2794(b), 42 USC § 300gg-94(b).

²² 45 CFR § 154.210.

²³ ACA § 2794(b), 42 USC § 300gg-94(b).

²⁴ ACA § 2794(b), 42 USC § 300gg-94(b); 45 CFR § 156.210

²⁵ Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, 77 Fed. Reg. 18,310, 18325-18,326 (March 27, 2012).

Plan Management	Consumer Assistance
QHP certification, recertification, and decertification	Support, administer, and oversee Navigators
QHP certification review: <ul style="list-style-type: none"> • Licensure in good standing • Service area • Network adequacy • Essential Community Providers • Marketing Oversight • Accreditation • Essential Health Benefits • Actuarial Value • Discriminatory benefit design • Benefits of meaningful difference • Rates (new and increases) 	Provide in-person assistance to consumers: <ul style="list-style-type: none"> • Filing an application • Receiving an eligibility determination • Renewing coverage • Comparing and selecting a coverage option • Enrolling in a QHP
QHP issuer account management	
QHP oversight and monitoring, including marketing	
Collect data	
Verify accreditation status and collect data for Exchange	
Collect and display quality data	
Coordinate with HHS on quality rating and enrollee survey	

A state choosing to partner with the Federally Facilitated Exchange must agree to fulfill all of the functions under Plan Management and/or Consumer Assistance in order to be a partner. States are eligible to receive federal Exchange Establishment grant funds, as a partner, to pay for additional expenses to prepare for fulfilling the partnership functions. It is still unclear how operational costs will be covered, or how the roles and responsibilities of the federal and state partners will be finalized, though likely through a Memorandum of Understanding.

The enhanced SERFF Plan Management functionality that will be available to States with state-based exchanges will also be available for use by States that chose to perform Plan Management as a part of a Partnership Exchange.

Further details on what will be expected of state partners are currently not available. States interested in partnering with the Federally Facilitated Exchange should begin discussions with their regional contact to ensure the state processes will meet the needs of the federal Exchange.

States must submit an application by November 16, 2012, expressing their intent to partners with the federal government and outlining their plan for fulfilling the functions by October 1, 2013.

2. Funding

States may receive funds from Exchange Establishment Grants for the cost of updating systems and processes to perform the plan management functions and/or consumer assistance functions required as part

of the partnership agreement. These funds are available through 2015. The grant funds may also be used by states to transition from a Partnership to a State-Based Exchange.

However, how ongoing operation costs will be covered is yet unclear. Will the state be responsible for raising the funds to cover operational costs? Will the states be reimbursed by the Federally Facilitated Exchange? Additional guidance and discussion is needed on this issue.

C. Federally Facilitated Exchange

1. Authority

If a State fails or elects not to establish a State-based Exchange, HHS is authorized to establish and operate an Exchange within the State.²⁶ HHS has stated that Sect. 1321 of the ACA “does not contemplate divided authority over an Exchange” and HHS “retain[s] ultimate responsibility and authority over operations and all inherently governmental functions” of a Federally-facilitated Exchange.²⁷

In guidance published in May 2012, HHS indicated that under a Federally Facilitated Exchange all QHP certification functions, including the review and approval of QHP premium rates, would be performed by HHS. However, States would also retain all existing statutory authority related to the review and/or approval of premium rates consistent with the procedures described in other sections of this White Paper, including those rates used by issuers for QHPs sold through the Federally-facilitated Exchange operating within the state. HHS has acknowledged that certification of a QHP rate filing by the Exchange would be contingent upon a State’s approval of the submitted rate, if appropriate. In addition, as stated above, States that received Premium Review grants would presumably continue to fulfill their obligations to provide the Exchange with information about rate practices and trends both within and outside of the Exchange.

2. SERFF

The enhanced SERFF Plan Management functionality that will be available to States with state-based and partnership exchanges will also be available for use by States that utilize the full federally facilitated exchange model in order to enable states to affirm plans are approved for use within the state, where the state has the regulatory authority to approve or disapprove.

²⁶ ACA § 1321(c), 42 USC § 18041(c); 45 CFR § 155.105.

²⁷ Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, 77 Fed. Reg. 18,310, 18,326 (March 27, 2012).